Joan Walters
Director

Illinois Department of Public Aid

Prescott E. Bloom Building
201 South Grand Avenue East
Springfield, Illinois 62763-0001

ACTION NOTICE

TO: All Participating Hospital Providers: Chief Executive Officers, Chief Financial Officers, and Patient Accounts Managers; and Ambulatory Surgical Treatment Centers

RE: OUTPATIENT REFORM

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Outpatient reimbursement rates and methodologies have been revised by the Department effective for dates of service on or after July 1, 1998. These changes include:

- Hospital Ambulatory Reform (HAR) list is replaced with Ambulatory Procedures Listing (APL) - Attachment C
- Tiered payment for Observation Services
- Tiered payment for Emergency Department services
- Reimbursement for salaried physicians in the Emergency Department - Attachment A

Reminder: APL services can be billed only if provided on the hospital premises or at Ambulatory Surgical Treatment Centers (ASTCs).

The hospital fee-for-service provider number can only be used to bill for hospital based services (those adjacent to or within the hospital campus). All covered services provided at any other location must be billed under the name and provider number of the physician who performed the services.

Ambulatory Surgical Treatment Centers will continue to be reimbursed for certain surgical and a limited number of therapeutic and diagnostic procedures at 75 percent of the rate reimbursed to hospitals.

AMBULATORY PROCEDURES LISTING (APL)

Effective with dates of service July 1, 1998, the Department of Public Aid will replace the **HAR** groupings with the **Ambulatory Procedures Listing (APL)**. The procedures are grouped and subgrouped as follows:

GROUP 1.	**SURGICAL**	**NEW RATES**
	(a) Surgical - Intensive	$1,914.00
	(b) Surgical - Moderate	1,119.00
	(c) Surgical - Low	802.00
	(d) Surgical - Very Low	306.00
GROUP 2.	**DIAGNOSTIC AND THERAPEUTIC**	
	(a) Complex Diagnostic and Therapeutic	$1,004.00
	(b) High-tech Diagnostic	323.00
	(c) Other Diagnostic	187.00
	(d) Therapeutic Procedures	145.00
GROUP 3.	**EMERGENCY DEPARTMENT PROCEDURES**	
	(a) Emergency Level I	$164.00
	(b) Emergency Level II	84.00
	(c) Non-emergency / Screening	17.20
GROUP 4.	**OBSERVATION SERVICES**	
	(a) 1 hour through 6 hours, 30 minutes	$79.00
	(b) 6 hours, 31 minutes through 12 hours, 30 minutes	236.00
	(c) 12 hours, 31 minutes or more	473.00
GROUP 5.	**PSYCHIATRIC SERVICES**	
	(a) Type A	$62.10
	(b) Type B	62.10
GROUP 6.	**REHABILITATION SERVICES**	$115.00

Each subgroup is defined further in Attachment B.

APL REIMBURSEMENT

Each APL subgroup will be paid at a single **all-inclusive rate**, based upon the group to which the procedure code is assigned. The APL rate includes all services provided in an outpatient setting for each day a client is treated. **The all-inclusive rate is considered to cover all services provided by salaried hospital personnel, all drugs administered and/or provided for take home use, all equipment and supplies used for diagnosis and/or treatment on the hospital premises, and all x-ray, laboratory and therapy provided to the patient on the same day, except as described below**. Procedures provided in an outpatient setting must be included on the Ambulatory Procedures Listing (APL) to be paid at the all-inclusive rate. If multiple APL services are listed on the UB-92, the Department will continue to reimburse the procedure assigned the highest rate. Attachment C to this notice is the new APL listing.

Exception: Emergency Department Reimbursement for Salaried Hospital Personnel

The services of salaried personnel may not be separately billed except for salaried physician services provided in the Emergency Department. Hospitals may now bill for the services provided by one salaried Emergency Department physician on DPA 2360 in addition to the APL billed on the UB 92. If more than one salaried physician provides services to the same patient, the services provided by additional salaried physicians are considered part of the all-inclusive rate and cannot be billed as Fee-for-Service (FFS).

If the hospital provides a non-emergency/screening service (Group 3(c)), the hospital has the option of billing for the Screening Services only on the UB-92 or FFS on a DPA 2360, but not both.

NOTES:

- Hemodialysis on the APL refers to all renal dialysis services other than chronic ESRD.
- Billing for outpatient psychiatric services, Type A and Type B will not be changed by APL.
- Emergency Department procedure code 00.55 will no longer be valid for dates of service after June 30, 1998.
- Outpatient Series claims may need to be split-billed to coincide with the July 1, 1998 effective date of this notice.

OBSERVATION SERVICES

Observation is established to reimburse services that are provided when a patient's current condition does not warrant an inpatient admission, but does require an extended period of observation in order to evaluate and treat the patient in a setting which provides ancillary resources for diagnosis or treatment with appropriate medical and skilled nursing care.

There will be three (3) levels of observation billing, based upon the number of hours that the patient is actually in observation. **The Department will not reimburse for Observation Services of less than sixty (60) minutes.** The levels are as follows:

Procedure Code	Time Period
00.69	1 hour through 6 hours, 30 minutes
00.68	6 hours, 31 minutes through 12 hours, 30 minutes
00.67	12 hours, 31 minutes or more

The total observation hours must be reported on the same line as observation revenue code 762 in Form Locator (FL)46, Service Units, as whole hours. For observation episodes in excess of one hour, partial hours are to be rounded to the nearest hour on the bill. For example, 6 hours and 31 minutes will be rounded up to 7; 6 hours and 30 minutes will be rounded down to 6. The Service Units must correspond with the Procedure Code on the claim. If observation service units do not correspond to the observation procedure code, claims will be rejected with the following new error message:

E80 - Invalid Units For Observation

Claims that reflect surgeries identified on the APL with "OBS", observation, must have a period of at least 6 hours and 31 minutes of observation following the surgical procedure. The appropriate procedure code 00.67 or 00.68 for the time period of the observation and revenue code 762, Observation, must be present on the claim, or the claim will be rejected.

The medical record must clearly document a physician's order to admit to observation and the amount of time the patient was in observation status.

The hospital should bill for both observation and other APL procedures on one claim form, but will be reimbursed only for the procedure with the highest reimbursement.

EMERGENCY DEPARTMENT SERVICES

Emergency Department services can be either emergency or non-emergency services. **The initial service must be provided at the hospital in its Emergency Department and must be directed or coordinated by the Emergency Department physician.**

The words "Emergency services", as used in this Notice, mean those services which are for a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, possessing an average knowledge of medicine and health could reasonably expect that the absence of immediate attention would result in placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part. The determination of the level of service reimbursable by the Department shall be based on circumstances at the time of initial examination, not upon the final determination of the client's actual condition, unless the actual condition is more severe.

Group 3, Emergency Department Services consists of two levels for emergencies which are Emergency Level I and Emergency Level II, and one Non-Emergency/Screening as described in the following topics. Each of the three levels will be paid at the rate assigned to that level of service.

Salaried Physicians Providing Services in the Emergency Department (Other than Screenings)

Beginning with July 1, 1998 dates of service, hospitals will be allowed to bill for **salaried** physician services provided in the Emergency Department on a fee-for-service basis. For this purpose only, salaried physician is defined as a physician who is salaried by the hospital; a physician who is reimbursed by the hospital through a contractual arrangement to provide direct patient care; or a group of physicians with a financial contract to provide Emergency Department care.

The **fee-for-service (FFS)** claim for **salaried** Emergency Department physician services will be subject to the following requirements:

- For each client, a hospital may bill for a visit or procedure for only one salaried physician's emergency level services in the Emergency Department. The hospital must bill on the DPA 2360 using its "400" series provider number and should also bill on a UB-92 for that patient for that date of service. The 2360 claim must include that physician's name and ID number in box 19.

- Under no circumstances can the physician's services be billed by both the physician and the hospital.

- If more than one salaried physician provides services to the same patient, the services provided by additional salaried physicians are considered part of the all-inclusive rate and cannot be billed as FFS.

Emergency Level I

Emergency Level I refers to "Emergency Services" provided in the hospital's Emergency Department for the alleviation of severe pain or for immediate diagnosis and/or treatment of conditions or injuries which pose an immediate significant threat to life or physiologic function.

Examples of Emergency Level I care include, but are not limited to:

- Anaphylactic allergic reaction
- Status asthmaticus
- Seizures of unknown origin
- Upper GI bleeding
- Miscarriage
- Acute chest pain
- Laceration involving major blood vessels or tendons

Emergency Level I services may be billed on both the UB 92 and the DPA 2360 as follows:

UB-92 Billing

- Bill on the UB-92, using APL procedure code 00.56.
- Report all procedures using HCPCS codes in FL 44 HCPCS/Rates, on the appropriate revenue code line. The UB-92 claim must contain at least one HCPCS code.
- UB-92 claim must contain revenue code 450.

Fee-for-service Billing - DPA 2360

- Bill for one salaried physician's professional visit or procedure on the DPA 2360 using CPT codes and the hospital's "400" series provider number.

Emergency Level II

Emergency Level II refers to "Emergency Services" that do not meet the above definition of Emergency Level I care, but which are provided in the hospital Emergency Department for a medical condition manifesting itself by acute symptoms of sufficient severity that urgent or unscheduled care is required.

Examples of Emergency Level II care include, but are not limited to:

- Dehydration
- Blunt head injury without loss of consciousness
- Asthma
- Ear infections

Billing instructions for Emergency Level II are:

UB-92 Billing

- Bill on the UB-92 using procedure code 00.57.
- Report all procedures using HCPCS codes in FL 44 HCPCS/Rates, on the appropriate revenue code line. The UB-92 claim must contain at least one HCPCS code.
- Revenue code 456 must be present.

Fee-for-service Billing - DPA 2360

- Bill for one salaried physician's professional visit or procedure on the DPA 2360 using CPT codes and the hospital's "400" series provider number.

Non-Emergency/Screening Level

Non-Emergency/Screening Level refers to those services provided in the hospital Emergency Department that do not meet the requirements of Emergency Levels I or II stated above. For such care, the Department will reimburse the hospital either applicable current FFS rates for the services provided **or** a screening fee, but not both.

Examples of Non-Emergency/Screening Level care include, but are not limited to:

- Single laceration which did not require suturing
- Sunburn
- Puncture wound
- Suture removal

Billing Options for Non-Emergency/Screening Services

The hospital is allowed to select the most appropriate billing mechanism on a patient by patient basis to bill for Non-Emergency/Screening services provided in the hospital's ER. No more than one of the options may be billed for any one calendar day.

- Option 1 - Billing for Non-Emergency/Screening Services Only

  If the hospital is billing for a screening fee only, the hospital may bill on the UB-92 using Revenue Code 451 and Procedure Code 00.58. This is permissible even if a non-salaried Emergency Department physician also bills. The screening fee payment is all-inclusive, and therefore the hospital may not bill for any professional or technical components of the services provided in the Emergency Department. Report all HCPCS codes on the claim.

- Option 2 - Billing Fee-for-Service for Professional and Technical Component Services Only

  If the hospital is billing for FFS only, the hospital may bill on the DPA 2360 for ALL services provided, including the professional and technical components of the services, using the hospital's "400" number. For example, Emergency Department visit **or** procedure(s) for a salaried physician and technical and/or professional components of labs, x-ray, EKG, etc.

Summary of Emergency Department Coding Changes

- Under APL, procedure code 00.55 is no longer a valid code for Emergency Department services. Claims which are submitted using code 00.55 will reject for dates of service on or after July 1, 1998.

- The following codes must be used to bill the level of Emergency Department services provided on or after July 1, 1998:

Revenue Code	Procedure Code	Description
450	00.56	Emergency Level I
456	00.57	Emergency Level II
451	00.58	Non-Emergency/Screening Level

- If the Emergency Department revenue code does not correspond to the appropriate new Emergency Department procedure code, the claim will be rejected with the following new error message:

E61 - Emergency Department Procedure Invalid For This Revenue Code

MISCELLANEOUS CHANGES

- **Outpatient Series Claims** may need to be split billed to comply with the effective date of this notice, July 1, 1998. Failure to do so may result in incorrect reimbursement. Series claims which cross the July 1 date will be priced based upon the "from" date in FL6.

- **Discontinued Category of Service.** COS 26, Clinic, will be discontinued effective with dates of service on or after September 1, 1998. After this date, use Category of Service 24, General Outpatient Service, for services provided in facilities adjacent to or within the hospital grounds.

- **APL PC Readable Files.** Files of the APL are available in machine readable format. These files correspond to the printed information found in Attachment C. These files may be obtained by sending a blank formatted DS/DD or DS/HD 3.5 inch IBM PC compatible diskette (no other media format will be accepted) along with a **self addressed and prepaid diskette mailer** to:

  Illinois Department of Public Aid
  Bureau of Comprehensive Health Services
  Attn: Audrey Thorington
  P.O. Box 19128
  Springfield, IL 62794-9128

  NOTE: No faxed requests will be filled. The Bureau of Comprehensive Health Services (BCHS) will be unable to fill requests for these files unless the requester supplies **the diskette and the pre-addressed and pre-paid mailer** for return shipment. Please include a voice telephone number so that you may be contacted in the event any question arises regarding your request, such as a bad diskette or missing or unpaid mailer.

- **Outpatient Billing Seminars**

  The Illinois Hospital HealthSystems Association (IHHA) is sponsoring one-half day Outpatient Billing seminars during July and August. The sessions will be held as follows:

Date	Location
July 21, 1998	Holiday Inn, Mt. Vernon
July 24, 1998	Crowne Plaza, Springfield
July 28, 1998	Metropolitan Chicago Healthcare Council, Chicago
July 29, 1998	Illinois Hospital & HealthSystems Association, Naperville
August 4, 1998	Holiday Inn, Collinsville
August 12, 1998	Illinois Hospital & HealthSystems Association, Naperville

If you have not already received registration notices, please contact the IHHA at 630-505-7777,

ext. 393.

Revised pages for the Handbook for Hospitals will be forthcoming.

Questions regarding this notice may be directed to the Bureau of Comprehensive Health Services at (217) 782-5565.

A. George Hovanec, Administrator
Division of Medical Programs

Attachments:

Attachment A provides information regarding Emergency Department billing.
Attachment B provides definitions for each APL group.
Attachment C is the APL list which replaces HAR.

Attachment A
(Revised 7/21/98)

HOSPITAL BILLING OPTIONS
For *Salaried Physician* Services Provided
In the *Emergency Department*

GROUP NUMBER AND NAME	UB 92 CLAIMS		DPA 2360 CLAIMS
1(a) Surgical - Intensive 1(b) Surgical - Moderate 1(c) Surgical - Low 1(d) Surgical - Very Low	APL	**AND**	Physician CPT procedure OR Visit
2(a) Complex Diagnostic and Therapeutic 2(b) High-tech Diagnostic 2(c) Other Diagnostic 2(d) Therapeutic Procedures	APL	**AND**	Physician CPT procedure OR Visit
3(a) Emergency Level I	APL Proc. Code 00.56 Rev. Code 450 HCPCS Code	**AND**	Physician CPT procedure OR Visit
3(b) Emergency Level II	APL Proc. Code 00.57 Rev. Code 456 HCPCS Code	**AND**	Physician CPT procedure OR Visit
3(c) Non-emergency/Screening:	Option I - Screening Only APL Proc. Code 00.58 Rev. Code 451 HCPCS Code must be reported.	**OR**	Option II - Fee-For-Service ALL services provided, including the professional and technical components of the services, using the hospital's "400" number. For example, Emergency Department visit or procedure(s) for a salaried physician and technical and/or professional components of labs, x-ray, EKG, etc.

Attachment B

GROUP DEFINITIONS

GROUP 1 - Surgical Groups

a. Surgical group 1(a) consists of intense surgical procedures. These surgeries require an operating suite with continuous patient monitoring by anesthesia personnel. This level of service involves advanced specialized skills and highly technical operating department personnel using high technology equipment. The rate of reimbursement for this group will be $1,914.
b. Surgical group 1(b) consists of moderately intense surgical procedures. These surgeries generally require the use of an operating suite or an Emergency Department treatment suite, along with continuous monitoring by anesthesia personnel and some specialized equipment. The rate of reimbursement for this group will be $1,119.
c. Surgical group 1(c) consists of low intensity surgical procedures. These surgeries may be done in an operating suite or an Emergency Department and require relatively brief operating times. Such procedures may be performed for evaluation or diagnostic reasons. The rate of reimbursement for this group will be $802.
d. Surgical group 1(d) consists of surgical procedures of very low intensity. These surgeries may be done in an operating room or Emergency Department, have a low risk of complications, and include some physician-administered diagnostic and therapeutic procedures. The rate of reimbursement for this group will be $306.

GROUP 2 - Diagnostic and Therapeutic Groups

a. Diagnostic and therapeutic group 2(a) consists of advanced or evolving technologically complex diagnostic or therapeutic procedures. These procedures are typically invasive and must be administered by a physician. The rate of reimbursement for this group will be $1,004.
b. Diagnostic and therapeutic group 2(b) consists of technologically complex diagnostic and therapeutic procedures that are typically non-invasive. These procedures typically include radiological consultation or a diagnostic study. The rate of reimbursement for this group will be $323.
c. Diagnostic and therapeutic group 2(c) consists of other diagnostic tests. These procedures are generally non-invasive and may be administered by a technician and monitored by a physician. The rate of reimbursement for this group will be $187.
d. Diagnostic and therapeutic group 2(d) consists of therapeutic procedures. These procedures typically involve parenterally administered therapeutic agents. Either a nurse or a physician is likely to perform such procedures. The rate of reimbursement for this group will be $145.

GROUP 3 - Emergency Department Services

"Emergency Services" are those services which are for a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, possessing an average knowledge of medicine and health could reasonably expect that the absence of immediate attention would result in placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part. The determination of the level of service reimbursable by the Department shall be based on circumstances at the time of initial examination, not upon the final determination of the client's actual condition, unless the actual condition is more severe.

Reimbursement for services provided in a hospital Emergency Department will be made in accordance with one of the three levels described below. Determinations of levels of Emergency Department service shall be based upon the symptoms and condition of the client at the time the client is initially examined by the physician and not upon the final determination of the client's actual medical condition.

a) Emergency Level I refers to "Emergency Services"provided in the hospital's Emergency Department for the alleviation of severe pain or for immediate diagnosis and/or treatment of conditions or injuries which pose an immediate significant threat to life or physiologic function. The rate of reimbursement for this group will be $164.
b) Emergency Level II refers to "Emergency Services" that do not meet the above definition of Emergency Level I care, but which are provided in the hospital Emergency Department for a medical condition manifesting itself by acute symptoms of sufficient severity that urgent or unscheduled care is required. The rate of reimbursement for this group will be $84.
c) Non-Emergency/Screening Level means those services provided in the hospital Emergency Department that do not meet the requirements of Emergency Levels I or II stated above. For such care, the Department will reimburse the hospital either applicable current FFS rates for the services provided **or** a screening fee, but not both. The rate of reimbursement for a screening visit will be $17.20.

GROUP 4 - OBSERVATION SERVICES

A group for observation services is established to reimburse such services that are provided when a patient's current condition does not warrant an inpatient admission but does require an extended period of observation in order to evaluate and treat the patient in a setting which provides ancillary resources for diagnosis or treatment with appropriate medical and skilled nursing care. Observation services will be reimbursed under one of three categories:

a. One hour through 6 hours 30 minutes of services with a reimbursement rate of $79.
b. Six hours 31 minutes through 12 hours 30 minutes of services at a rate of $236.
c. Twelve hours 31 minutes or more of services at a rate of $473.

GROUP 5 - PSYCHIATRIC SERVICES

A group for psychiatric treatment services is established to reimburse for certain outpatient treatment psychiatric services that are provided by a hospital that is enrolled with the Department to provide inpatient psychiatric services.

a. Group 5(a), Type A Psychiatric Clinic Services, as defined in the Illinois Administrative Code at 89 Ill. Adm. Code Section 148.40(d)(2) and the Illinois Medicaid State Plan will be reimbursed at $62.10.
b. Group 5(b), Type B Psychiatric Clinic Services, as defined in the Illinois Administrative Code at 89 Ill. Adm. Code Section 148.40(d)(2) and the Illinois Medicaid State Plan will be reimbursed at $62.10.

GROUP 6 - REHABILITATION SERVICES

A group for physical rehabilitation services is established to reimburse for certain outpatient physical rehabilitation services that are provided by a hospital that is enrolled with the Department to provide inpatient physical rehabilitation services. The rate of reimbursement for this group will be $115.